

# NORWAY CONQUERS VENEREAL DISEASES\*

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In many parts of the world venereal infections still offer a major threat to marriage, family life, and reproduction. They remain a threat even in Norway, where the sharp rise in incidence when the pre-war control programme was sabotaged during the Nazi occupation bears witness to the need for constant vigilance, especially in a maritime nation.

Norway abolished legalized prostitution in 1887 (Hovde, 1943), and about 1902 a comprehensive Bill for the control of infected prostitutes was rejected in Parliament lest it re-introduce recognized and regulated prostitution. In 1923, a new proposal was rejected by the Department of Social Affairs, but certain measures were introduced piecemeal before World War II for the care of sailors, especially in the seaport towns.

Paradoxes came with the Nazi occupation. For example, the official Nazi code for public morals was patriarchal, anti-feminist, anti-abortionist, and anti-contraceptionist, and was not unlike that of Norway's pious mission groups which were permitted to meet during the Occupation. The Nazis closed the Oslo birth control clinic, falsely accusing it of abortionist practices. They seized Max Hodann's books in certain public libraries, and published their own version of the doctrine of race hygiene (Fuglesang, 1944), which, in its turn, was promptly expunged from Norwegian libraries after the war. The Germans were forbidden to report cases of V.D. to the Norwegian public health authorities and remained outside the control of the local health officers.‡ There was plenty of paper money, few goods, and some of the "doom-philosophy" of eat, drink, and be merry! Some fraternization with Norwegian girls occurred and some of their offspring

now present adjustment problems in the Oslo schools. As in all war areas, the incidence of V.D. rose sharply in Norway during the occupation.

After the Liberation, under an ordinance dated June, 12, 1945, between 2,000 and 3,000 infectious cases were quarantined in a colony. This ordinance expired in October, 1946, and was followed by the law of December 12, 1947, which provided for team work by public health and police authorities, protective agencies, and institutions, and for public education in physical sex hygiene.

Historically, the connexion between general sex education and the public health campaign against venereal diseases preceded the war, and was carried on as a public health programme, not combined, as in the U.S.A., with a programme of sex education in terms of moral purity or of positive psycho-social goals and rewards. It is true that Norway's world-famous health director, Karl Evang, first made his reputation as editor of a periodical (Evang, 1935) which crusaded both against venereal disease and against general sex ignorance and taboos. This work stemmed from the overwhelming question-mail that poured in upon him in response to a health-column he wrote for a popular newspaper. It is also true that the extremists of the opposition attribute the recent sex education programme of the Church and Education Department to Evang, whose bureau is part of the Department of Social Affairs. But I was assured in various quarters that his influence was very indirect and general. Since World War II there has been no extensive *general* sex education as we know it, and the gains in venereal disease control cannot be attributed to this. The 1947 campaign of the Norwegian People's Aid (*Norske Folkehjelp*) for enlightening the public on the physical menace of V.D. (Helsedirektøren, Oslo, 1946a, b, 1947) was stimulated by the post-war increase and by the widespread ignorance§ revealed by Gallup Polls. Of those

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‡ Moreover, the Occupation authorities forbade German citizens to go to Norwegian physicians for the treatment of V.D. This had a bad effect as many Germans were afraid to visit their own doctors for fear of degradation or spoiling their chances of advancement (H. C. Gjessing, personal communication, 1954).

§ In Sweden, by contrast (in April, 1946), 94 per cent. knew that they must do something if a venereal disease infection is suspected; 52 per cent. believed syphilis curable, while 40 per cent. did not know.

questioned, 85 per cent. favoured sex education in the grammar schools (Rummelhoff, 1949). Since 1948 the public have been persuaded (Helsedirektoratet, 1948) to accept the enforcement of that combination of compulsory reporting, follow-up of sources, and practically free\* but compulsory penicillin treatment, to which the startling reduction of civilian V.D. rates in Norway is attributed by Dr. H. C. Gjessing, who heads the V.D. Division of the Oslo Board of Health (Gjessing, n.d., 1945, 1949, 1951). Of the combined factors, the free issue of penicillin since 1946 to the physicians by the chemists, who are state-reimbursed on requisition, is considered to be the most important.

Cases of venereal disease are not reported by name,† but since 1948 a special report on other details including sources of infection has been required for each case, and the physicians are said to cooperate fully. The name is given only if treatment is neglected or refused and active legal compulsion is required. Cases are summarized by the local health authorities and reported to the National Department of Social Affairs. No spot-maps are kept, but sources of infection are charted. The only effective sanction for the revealing of sources of infection is the threat of non-treatment at the public clinic. Some infections, especially old cases in the later stages, are being found and reported through the increased practice instituted by employers of routine physical inspection for factory jobs, which is often repeated annually.‡

Since "professional" prostitution is prohibited and there are no brothels, the chief sources of infection are girls who have other jobs.§ They are reported to the police only if they do not attend for treatment when notified, or in Oslo when called on by a nurse. Such cases are dealt with by the "Moral Police", consisting largely of women in plain clothes. There are no "raids on prostitutes" in the American sense. Premises are entered only on responsible complaints of disorder; neighbours seldom complain, and prostitutes are so few that this aspect is of little significance. Flagrant disorder is rare. No "lock-hospital" is used; the regular dermatological wards of Oslo's large public hospital suffice when hospitalization is required.

\*There is a nominal fee (kr. 2) for treatment, but since 1911 venereal diseases have been covered by health insurance which embraces all those below a certain income and many (voluntarily) above that level.

† Providing the longest series in Europe (since 1884), according to H. C. Gjessing.

‡ The foregoing statements are largely based on interviews with Dr. Iversen of the Oslo Board of Health and with Dr. Gjessing of the Venereal Division.

§ In the post-war peak of incidence the Oslo chart shows only infections of Norwegian girls. German soldiers had to be treated by German army doctors.

Treatment is apparently no longer dreaded by patients.|| Most local patients go to private physicians, since insurance covers much of the cost. Of Oslo's 612 new gonorrhoea cases in 1953, 251 (41 per cent.) were diagnosed and treated at the Board of Health Clinic.

In Denmark the treatment of venereal diseases has been free and compulsory since 1790, though the new drugs have recently made the programme far more effective. The system in other Scandinavian countries seems to have been adopted or adapted from that of Denmark. This principle of free but compulsory treatment does not produce concealment, since privacy is safeguarded, and hospitalization is only resorted to for persistent and careless carriers, or for serious degrees of disease. The decrease in new cases is comparable to that in Norway, with comparable rises due to the wars.¶

Finland's system of venereal disease control is comparable to that of Denmark, Sweden, and Norway; in Helsinki two venereal disease clinics—one for each sex—provide free treatment (Brunn, 1950).

### Incidence in Norway

The rates per 10,000 of population for gonorrhoea and syphilis in Norway (Fig. 1, overleaf) show the war-time increase, the post-war peak in 1946, and the rapid decline thereafter. The increase in 1946 after the Liberation to above the war-time rate is attributed by some to increased accuracy in reporting, since physicians could only obtain access to the free penicillin treatment by reporting their cases (Strøm and Grette, 1948). Dr. Gjessing thinks that the post-war increase was due to improved economic conditions, the effects of which were thereafter offset by penicillin (cf. Haustein, 1926). By 1950 the incidence was reduced to 701 new cases of syphilis (of which 426 were in cities), and 2,415 new cases of gonorrhoea (of which 1,711 were in cities). The national rate (1950) for acquired syphilis was 2.1 per 10,000 population: that for all venereal diseases was 9.6 per 10,000.\*\* The number of new cases was reduced by almost one-third in 2 years: the rate declined by 15 per cent. in 5 years. The new cases were concentrated heavily in Oslo, with Bergen a lagging second. In 1951 the figures were further reduced (Statistisk Arbok, Norge, p. 40, 1953) and these gains have been maintained in 1952 and 1953 (Table I, overleaf).

|| Interview with Dr. Iversen, Oslo Board of Health.

¶ "Social Denmark" (1945-47), pp. 218-20. Socialt Tidsskrift, Copenhagen.

\*\*\* "Sunnhetstilstanden og Medisinal Forholdene, 1950" pp. 57-58, 147. Statistisk Sentralbyrå, 1952.

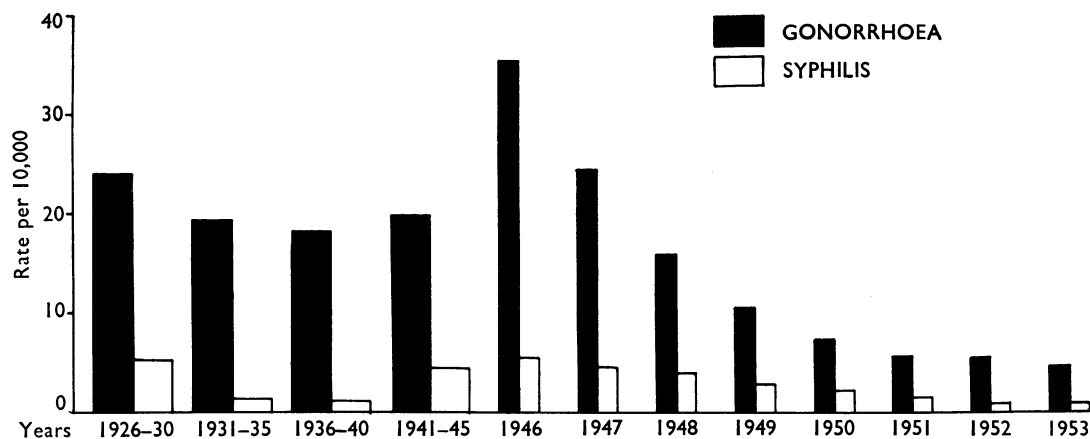


FIG. 1.—Rates of gonorrhoea and syphilis per 10,000 population, Norway, 1926-53.

TABLE I  
NEW CASES AND RATES PER 10,000 POPULATION, NORWAY

Year	Gonorrhoea		Syphilis	
	Cases	Rate	Cases	Rate
1950	2,415	7.5	701	2.1
1951	1,947	5.8	477	1.4
1952	1,946	5.8	304	0.9
1953	1,648	4.9	308	0.9

It was the war and post-war peaks that prompted the campaign of public education and circulation of standard pamphlets against and about venereal infections, by the National and Oslo health authorities, and by the *Norske Folkehjelp*. Further publicity is now hardly considered necessary, since the facts are widely known, the peak has been passed, and cure is easy.\*

#### Urban Incidence

V.D. rates in Oslo have been recorded since 1876 (Fig. 2, opposite).

Fluctuation has been very marked, with high points in 1882 (120 per 10,000), 1899, 1916, 1925, 1928, 1946; and low points in 1888, 1907, 1940, 1950. The recent range for gonorrhoea was from 117 per 10,000 population in 1946 to 16 per 10,000 in 1950; for syphilis it was 27 per 10,000 in 1943, against 3 per 10,000 in 1939 and 1950.† If only primary and secondary cases are included in the rate,

as in the U.S.A., the last figure would be only 1 per 10,000.‡

It will be noted that Oslo had syphilis well under control before World War II. This port of 434,047 people had in 1953 only 675 new cases of venereal disease, comprising gonorrhoea 612 and acquired syphilis 39, as well as 24 cases of late latent and tertiary syphilis.§ This represents a rate of 14 per 10,000 for gonorrhoea, and of 0.9 per 10,000 for primary and secondary plus early, latent, and congenital syphilis (Gjessing, 1953, 1954). Of the sources of infection, 39.5 per cent. were discovered, as against 38.6 per cent. in 1949 and 30.7 per cent. in 1950. Of local sources, 47 per cent. were discovered.

In Stavanger, a west-coast port of Norway, the incidence of venereal disease was reported to be high during the war, many persons being infected by the members of the occupying German forces.|| Now there is no brothel, the few prostitutes are local girls, and there are only eight or ten known carriers. The police are brought in only if such girls go aboard the ships.¶ There are perhaps forty new syphilis cases and 130 to 140 new gonorrhoea cases per year, and the problem is under control.\*\* An educational campaign is thought to have contributed to this reduction.††

In Arendal, a southern port, cases are now also few, and infected persons come for treatment

† Beretning om Kjønnssykdommer i Oslo i Året, 1950 (mimeo. Oslo, 1951).

§ Oslo Helseråd, 1953 (Annual Report).

|| Venereal diseases have, throughout the history of the western nations, been blamed on foreign contacts. In Oslo in 1952, of 695 new cases of gonorrhoea 13.4 per cent., and of 75 new cases of syphilis 18.7 per cent were of foreign origin.

¶ Interview with local police inspector.

\*\* Interview with Dr. Dahl, City Physician, Stavanger.

†† Interview with Dr. Jørgen Brommeland, Stavanger.

\* This opinion is based chiefly on an interview with and reports from Dr. H. C. Gjessing.

† Cf. letter from Oslo Helseråd, January 31, 1951; Statistisk Årbok, Oslo (Annual).

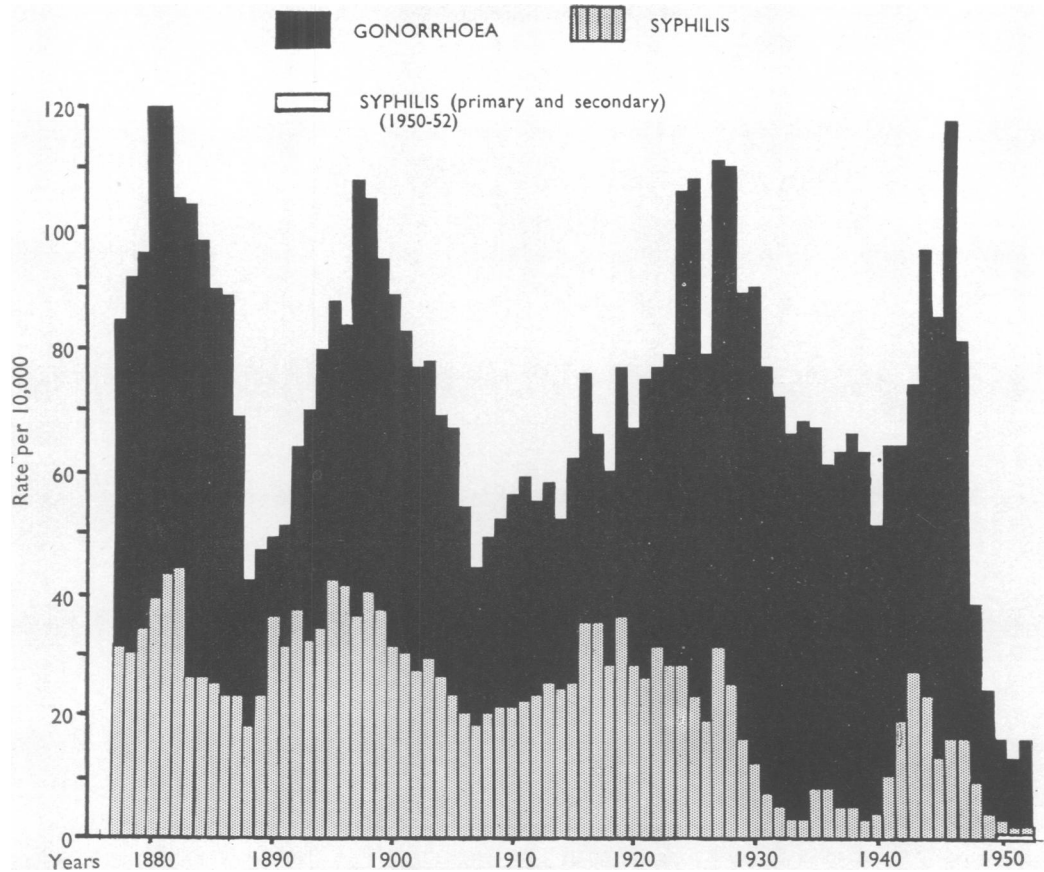


Fig. 2.—Rates of gonorrhoea and syphilis per 10,000 population in Oslo, 1876–1953.

voluntarily, or on the first warning letter ; the police have not yet been invoked.\*

#### Rural Incidence

Syphilis rates (primary and secondary) for Norway outside Oslo since 1876 have ranged from one-sixth to one-third of the rates in the capital (Haustein, 1926). The war produced a relative increase in *rural districts* compared with the pre-war ratio. Whereas before the war syphilis appeared twice as frequently among males, and gonorrhoea thrice as frequently, during the war gonorrhoea became equally frequent in males and females and syphilis twice as frequent among females as among males.

Venereal diseases are now rarer in the rural areas than in the cities. In 1950, cases of gonorrhoea in rural Norway were only 42 per cent. of those in the urban districts.†

#### Comparison with Other Scandinavian Countries

Fig. 3 (overleaf) presents rates for gonorrhoea and syphilis per 10,000 population for all the Scandinavian countries. The syphilis rates are not strictly comparable because of minor variations between the countries in the grouping of different diagnostic stages. The rates for Denmark include primary and secondary cases and infections acquired within 12 months. The Swedish rates include latent acquired infections of up to 3 years' duration and congenital cases up to 3 years of age, in addition to primary and secondary cases. The Norwegian rates represent all patients, including late latent, tertiary, and congenital cases. From 1953, however, the Norwegian syphilis rates are calculated only on the basis of primary, secondary, and early latent cases (Gjessing, 1954).

**Sweden** (Statistisk Årsbok, Sverige, 1953, pp. 8, 244).—The rate for syphilis shows a trend similar to that of Norway, but in Sweden there has recently

\* Interview with Dr. Knut Egeberg, City Physician, Arendal.

† "Sunnhetstilstanden og Medisinal Forholdene, 1950", p. 147. Statistisk Sentralbyrå, 1952.

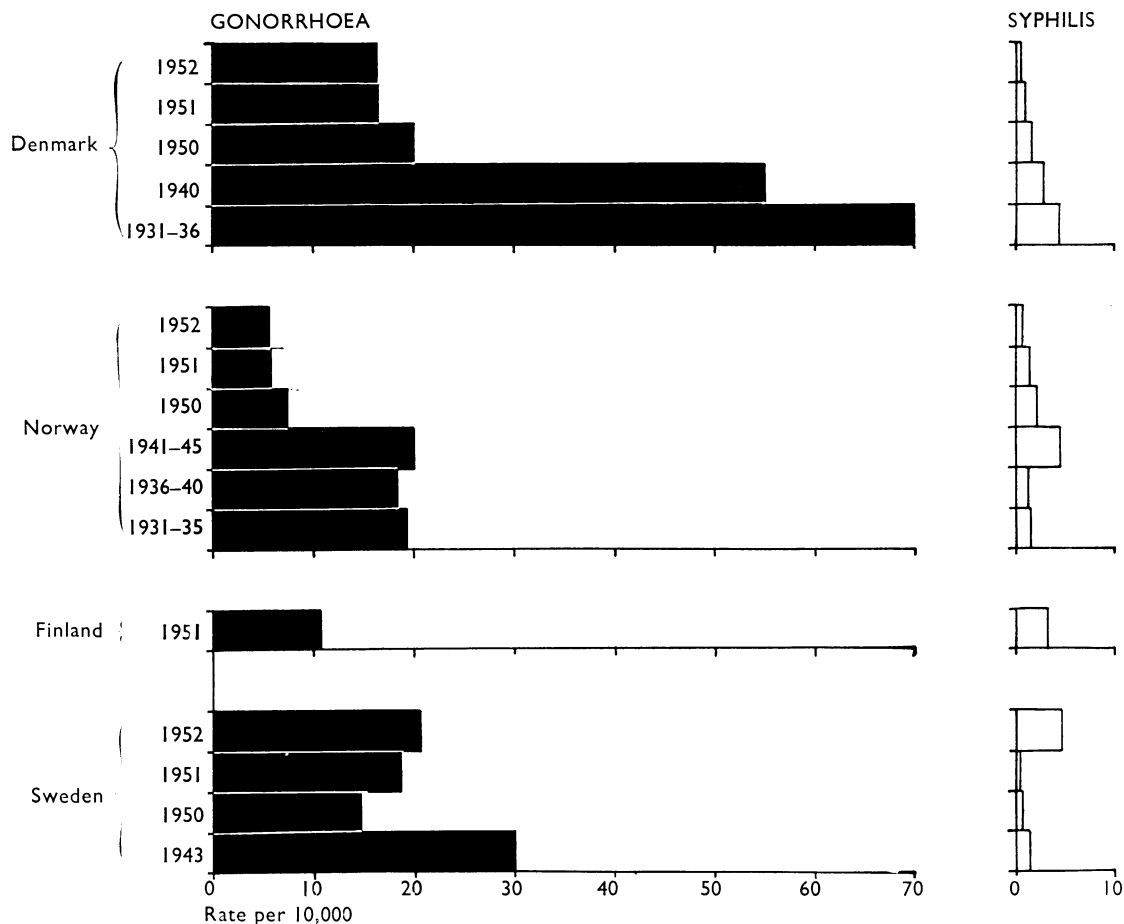


FIG. 3.—Rates of gonorrhoea and syphilis per 10,000 population in Scandinavia, selected years.

been a slight increase in the rate of gonorrhoea (Table II). The combined rate for syphilis and gonorrhoea in Sweden in 1952 was 21·3 and the increase in the rate for gonorrhoea occurred particularly in persons about 20 years old.

TABLE II  
V.D. RATES PER 10,000 POPULATION, SWEDEN

Year	Gonorrhoea	Syphilis
1943	30	1·5
1950	14·5	0·89
1951	18·7	0·67
1952	20·8	0·47

**Denmark\*** (Statistisk Årbog, 1951, p. 41 ; 1953, pp. 5, 34).—Venereal disease was well under control

\* "Socialt Tidsskrift" (1945-47), Copenhagen, pp. 219-20.

before World War II, increased during the occupation, and has since fallen rapidly (Table III).

TABLE III  
V.D. RATES PER 10,000 POPULATION, DENMARK

Year	Gonorrhoea	Syphilis
1906-1916 (average)	120-140	40-50
1931-1936 (average)	70	4-5
1940	55	3 (rural 1)
1950	20	1·8
1951	16·4	1
1952	16·3	0·5

**Finland** (Statistisk Årsbok, 1952, p. 60).—The rates for 1951 were 0·32 per 10,000 for syphilis (not

including tertiary cases), 10·8 for gonorrhoea, and 14 for new cases of venereal diseases. Until 1939, Finland's V.D. rate was higher than Sweden's, but in that year syphilis first fell below 1,000 new cases and gonorrhoea below 12,000 new cases. In 1946 syphilis increased to 8,000 and gonorrhoea to 24,000 cases, and the infections were scattered through the country by the demobilized army during this post-war peak. But now, as in Norway, V.D. infection is limited almost exclusively to the seaports; 1950 showed only 400 new syphilis cases and 5,000 new gonorrhoea cases.

### Venereal Disease and the Army

Prophylaxis specifically for the prevention of venereal diseases has been available to civilians in Norway through several channels, including commercial sales and physicians' prescription. Advertising is legally forbidden, but proceeds by transparent euphemisms, such as "hygienic articles". Prophylaxis became a public issue only in relation to army practices,\* and especially in regard to Norway's so-called "Germany Brigade", the token occupation force kept in the British Zone of Germany until 1953. Dr. H. C. Gjessing's reports show that practically all the new cases of V.D. brought into Norway since the war, apart from those involving sailors in the ports, came from the "Germany Brigade". It was a self-defeating price to pay for a symbol of victory, national pride, and official morality!

The post-war increase in the incidence of both civilian and military venereal disease created an emergency. Enlisted men found infected were turned over to civil health authorities, and the tests gave only 0·14 per cent. positive reactions.† Welfare work, recreation, and propaganda were increased, but their effectiveness was discounted by the army physicians.

It is interesting to note that prophylaxis has been and is compulsory for merchant seamen,‡ an important group in the Norwegian labour force, without apparent objection from religious groups, some of which maintain elaborate social services for sailors on board and in ports, even overseas. Prophylactic packets had been issued free to the army during the war and the practice was continued in Norway in the first year after the war. But in 1946 strong opposition arose from various religious groups.

\* Cf. "Forhandling i Stortinget", No. 164, p. 146, July 10: Interpellation from Ramndal (Liberal) on the moral level among the soldiers. General debate, Hauge replying.

† U.S. white recruits 1940-42 showed 1 per cent. positive at 20-25 years of age.

‡ Interview with Dr. Iversen, Oslo Board of Health.

Because of the public controversy, the Defence Department set up a special committee in 1946. This military committee represented the army medical corps, the three defence branches, the chaplains, the welfare organizations, and the health directorate. Before July, 1947, a small informal committee met to organize the opposition. Lutheran leaders headed by Bjarne Hareide launched a giant petition of protest, supported by religious and conservative groups, claiming that the standardizing of prophylactic procedures would indicate official acceptance if not endorsement of extra-marital indulgence. The petition circulated through organizations and individuals, and was supported by 442,000 people. The argument was not presented on legal grounds. It was claimed that whereas soldiers had hitherto been individually free to purchase prophylactics, official recognition of their use would seem to offer an assurance, an advertisement, an encouragement to indulgence, objectionable to Christian morality.§ This claim that the army procedure would lead some boys into sexual intercourse who would not otherwise be corrupted was partly countered by the findings of a voluntary questionnaire answered by 421 of 423 recruits of 20 to 21 years of age, 82·2 per cent. of whom had previously had intercourse: 71·7 per cent. before the age of 19, the year of conscription, and 36 per cent. at the age of 16. On November 20, 1947, the report from the military committee (No. 204, 1945/46) was approved unanimously except for the section on the routine issue of packets, but this section was also passed in Parliament by 76 to 45 votes. The Defence Department continued the practice until 1948, but packets have since been issued only on personal application to the health corporal, who was to keep no list, but to report to the divisional medical officer if any one soldier requested so many that re-sales were suspected. Despite dissent on the issue of packets, there was unanimous approval of setting up prophylactic stations, but this was done for the "Germany Brigade" only. The army also traced the sources of infection in 52 per cent. of the cases, a larger percentage than that obtained in civilian medical practice. Sources and soldiers discharged uncured continued to be reported to the civilian health authorities. A study of 113 infected cases showed that 99 (88 per cent.) had not used condoms, and that in three of the remaining 14 the condom had broken. Without information on the number of exposures without preventives and without infection, there is no proof of the effect of condoms,

§ The foregoing account is based upon an interview with Dr. Bjarne Hareide, director of the Institute for Christian Propaganda.

A similar study in Sweden gave 81 per cent. Studies of students showed much lower rates: 58 per cent. and 36 per cent.

but the rates of infection diminished with their use.

As late as 1952 the newspapers carried front-page stories with such headings as "Norwegian Soldiers' Intercourse with German Girls Statistically Revealed". The many cases of venereal disease were said to be due to drink and to neglect of preventives. According to Berdal (1950), 42 per cent. of the soldiers in the latest brigade had intercourse in Germany. There were 202 new cases of syphilis and 646 new cases of gonorrhoea among 22,000 Norwegians in Germany in 2½ years. In 6 months, one brigade had a syphilis rate (14 per 1,000) seven times that in the home divisions. During 6 months of 1949, the rate was 4·1, but in 10,000 men in the home divisions not a single case was reported. In the same period the gonorrhoea rate for the "Germany Brigade" was thirteen times the rate for the home divisions, which was almost down to the civilian level. For some reason sergeants' rates were six or seven times higher than those of private soldiers and officers. While 78 per cent. of infections occurred in Germany, the rate for those on leave in other continental countries was higher (in one brigade ten times higher) than for those remaining in Germany. Of those exposing themselves to risk only 30 per cent. of a sample of 2,700 men used condoms. The high rates were also attributed in part to the location of the camps, to the largely unchecked increase of V.D. in post-war Germany, the accessibility of German women, and the use of alcohol. The recent reduction of these rates in units serving in Germany was attributed in part to propaganda and instruction. There had been no reduction in German civilian rates.

These military, religious, and preventive aspects are mentioned here because of the continuing recurrence of war and occupation situations in overseas armed forces, and the factors of public opinion involved in their control. So far as Norway is concerned, the withdrawal of the "Germany Brigade" in 1953, and the virtual elimination of venereal disease in Norway, make prophylaxis no longer a public problem—though facilities are still accessible. Dr. Gjessing considers that penicillin is now so

effective against gonorrhoea that there is relatively less need than formerly for prophylactics.\*

From the present evidence it seems clear that Norway has now protected its families from venereal diseases to the point where even a programme of education for family life (which should of course retain the major facts) needs to lay little stress on the subject as compared with the normal personal, familial, and social aspects of sex.

### Summary

(1) The development of venereal disease control and certain aspects of public education on venereal diseases in Norway are outlined. The interruption of these efforts during World War II is described.

(2) The fluctuations in the annual rates for gonorrhoea and syphilis in Norway are presented together with those for the other Scandinavian countries. The rapid fall in recent years is particularly noted.

(3) The problems of venereal diseases and the use of prophylactic measures in the Norwegian occupation brigade in Germany are described.

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\* Cf. also interview of Dr. Mellbye of the National Health Department, November, 1950.